ETHICAL ISSUES IN ATTENDING PHYSICIAN-RESIDENT PHYSICIAN RELATIONS*

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THE attending physician-house staff physician relation is quite complex. There are no clear-cut definitions of the roles played by either house staff or attending physicians, and while the basic concept seems to regard medical education as a continuing process, interactions between the participants are diverse and ever changing. Simply, any physician's identity and role is directly related to and modified by changes in technology, legislation, administrative regulation, reimbursement mechanisms, and society's general needs, but everyone views the attending physician as an authoritative figure. Medicolegally, academically, and socially he is responsible for the kind and quality of care given to patients. He ultimately coordinates medical manpower, medical technology, and medical education related to his patient, but during recent years the concept of the attending physician has expanded to include various roles. In university teaching hospitals, full-time attending physicians may be solely involved in research or may be partially involved in the house staff training program, make ward rounds, or give conferences. Another type of attending physician seeks private practice and spends most of his time directly caring for patients. He may also have an active part in the training program but in recent times suffers an inferior academic image in contrast to that of the full-time academic researcher.

The house officers' image is equally diverse, and even their legal identity is in crisis. To the National Labor Relations Board they are students, but many house staff groups struggle for recognition as hospital employees. They are called upon to start intravenous lines, draw blood, admit patients, wheel patients from the radiology department, search the

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literature, and teach medical students. Whether they are cheap labor hired by the hospitals, patient-sitters for private doctors, teachers or medical students is subject to much discussion. In reality they are all of these. Moreover, in addition to medical responsibilities, both attending and house staff physicians have personal lives which require time, effort, and compassion to maintain marriages, raise children, and pursue other interests.

Interns and resident physicians are neophytes in the medical world, insecure but idealistic and optimistic about their profession. They may view the attending physician as both a sourse of medical information and a paragon of medical ethics. But, just as house staff members vary widely in their values, willingness to perform, and reliability, attending physicians may fall short of ideal medical educators and ethical practitioners. A young physician-in-training must sift through the morass of attending physicians to find those with whom he can identify and whom he can emulate. Through this process he acquires a sense of morality, maturity, and commitment as he increases his medical knowledge.

It should be obvious then, that resident physicians are professionally insecure. No longer medical students and not yet full attending physicians, they are in limbo. On one hand they are deeply involved with patient care and service, on the other they maintain an academic profile—learning and teaching medicine. Further, they enter residency training with certain ideas, values, ethics, and goals. They hope that through their residencies these ideals will mature as they become contributing physicians. The extent to which independence, knowledge, and skills develop may be directly related to well-structured patient-care-oriented programs. Schedules are exhausting and any pupillary status is easily abused by attending physicians, nurses, and patients. Resident physicians learn most through actual patient contact, emergency situations, conflicts, and personal misjudgments.

In a structured teaching program we might review the attending-resident physician relation as a provider-consumer relation, the nature of which is more elusive and ambiguous than that of the typical student-teacher model and within which the roles of teacher and learner are often interchanged. Attending physicians often rely on resident physicians for current literature and procedures. They admit their patients to particular hospital floors seeking resident physicians perceived to be well read and responsible enough to coordinate patient care. Frequently, attending physicians offer to the house staff patients who present diagnostic dilemmas, and generally the

resident physician accepts the academic challenge. Yet some attending physicians are intimidated and frightened by bright, aggressive residents who may seem to take over the case once the patient is admitted. We have all heard complaints from attending physicians about losing control of cases on "regionalized floors" or in surgical programs. In extreme attempts to gain independence, house officers have been known to place signs and notices and to demand that attendings write no orders on charts without consulting them. House officers must remember that attending physicians provide the clinical material, have developed rapport with their patients, and know them. We must honor the commitment of the practicing physician to his private patient. He may have insight into the patient because he followed him so long, and the private patient wants to be cared for by his private doctor. It is possible that the patient might have refused admission or signed out of the unit if he thought that his care were coordinated or his surgery performed by a resident physician.

Patients I have met have always assumed that their doctor was the "professor" who would instruct the house staff. Some patients have even refused examination by residents. Rarely have I admitted a private patient who felt that the resident acted independently or could cure on his own. I have found that in such cases it is best to introduce myself as an agent of the private physician. This generally sets a good tone and the patient relaxes enough to be more open and honest. It alleviates the awkward feeling of "where do I fit into the already established doctor-patient relation?"

Resident physicians' attitudes toward attending staff physicians vary. Those who honor their commitment to teaching rarely find residents antagonistic, but attending physicians who fail to communicate with resident physicians find them less congenial. Some attending physicians may be grateful to a house officer who discovers medical problems not previously suspected, but others become defensive and vindictive if they feel residents are too smart for their own good. Attending physicians who do little teaching and fail to keep up with newer concepts often have most difficulty with the house staff. Problems arise when house officers are required to care for the patients of attending physicians for whom they have little respect or suspect to be uninterested, ungrateful, or morally nonchalant. In extreme cases resident physicians may disregard orders from such physicians and seek advice as to appropriate management from attending physicians with whom they have a good rapport.

As physicians, we are all confused by external pressures which are changing the medical profession. We are not sure that as resident physicians or independent practitioners we shall in the future even be permitted to exercise our judgment or intellectual curiosity. Third-party payors, while providing physicians good incomes, wreak havoc with the profession as they attempt to control the type of care extended to their subscribers. They and government have changed our training programs by entitling all individuals to private physicians. The old concept of a ward service has been virtually eliminated, and hospital-utilization review and retrospective review by third-party payors, although necessary in some areas, preclude admissions for diagnostic evaluation. Such patients at one time were the most interesting teaching cases. It is only natural that as third-party payors seize control and hospitals yield to new cost-containment policies attending-house staff physician relations may be further aggravated and frustrated.

We can all think of other frustrations in the attending-house staff physician relation, but the strengths are more prevalent and the question remains how to improve these relations.

At Lenox Hill Hospital we have taken steps to reinforce the relation between attending physicians and house staff. Residents are represented on the medical board and on all the hospital committees. This exposes us to various levels of hospital decision making and participation in policies which may directly affect our relation with patients and other members of the health-care team. In our formal training programs we utilize the regional floor concept to enhance house-staff participation in the care of private patients. On a 20 to 30-bed unit, a team of residents, interns, and medical students work closely with the nursing staff and private physicians to coordinate medical care. Private patients seem to enjoy the closely monitored unit and house-staff rounds every day. The resident is part of discharge-planning coordination, and has considerable control over the admissions and discharges in his unit. One major drawback is the actual role of the ward-teaching attending physician in contrast to the role of the admitting physician. From experience these roles are loosely defined, and harmony on the ward depended on individual personalities. But it seems obvious that to have house staff training programs in this struggling era of private medicine, admitting attending physicians may have to take a back-seat role and offer only unofficial guidance to the regional team. The ward attending physician should supervise and coordinate all patient-care duties

on that floor. Finally, because working closely with house staff as a regional leader provokes the attending physician to reread his textbooks and journals, it provides the best possible continuing medical education. By meeting his responsibilities through day-to-day contact with house staff, the attending physician is forced to update his medical knowledge and skills. Because the public is making us think in terms of recertification, relicensure, and continuing medical education, mandatory participation in house-staff teaching might assist the attending physician to meet developing new requirements.

House staff and attending roles are not clearly defined and today, because of new external pressures, are changing even more rapidly. We interact on many levels—teachers to learners, providers to consumers, colleague to colleague, and friend to friend. Although many inadequacies and frustrations exist within our present system of postgraduate medical training, attempts are presently being made to develop systems in which quality patient care can be delivered in a teaching setting by a balanced attending-house staff team. We could have gone into private practice after a year of internship, but those of us who are residents have committed ourselves to a continuing learning process. To achieve our goals of medical competence and specialization we need attending physicians as our professors, our mentors, our parents, and a source of confidence for us. We simply could not function without them. If we can establish good working relations, the benefit will be felt by all of us and most importantly by our patients.